

OHIO TRAFFIC CRASH REPORT

OH-1 (Rev. 1-82)

LOCAL REPORT NO 15-17673		<input type="checkbox"/> OH-2 <input type="checkbox"/> OH-3	Lebanon Police		0830300		ODHS USE ONLY - 00 NOT MARK ABOVE				LOCAL FILE NO
REPORT TAKEN <input checked="" type="checkbox"/> AT STATION <input checked="" type="checkbox"/> AT SCENE	NO OF VEH PEDESTRIANS INVOLVED 2	CRASH SEVERITY (CHECK MOST SEVERE) <input type="checkbox"/> FATAL <input type="checkbox"/> INJURY <input checked="" type="checkbox"/> PROPERTY DAMAGE ONLY			COMBINED VEH/PROP LOSS <input checked="" type="checkbox"/> OVER \$150 <input type="checkbox"/> UNDER \$150	HIT SKIP <input type="checkbox"/> SOLVED <input checked="" type="checkbox"/> UNSOLVED					
IN COUNTY OF WARREN			IN <input checked="" type="checkbox"/> CITY LEBANON			DATE OF CRASH 10/6/15	DAY TUE	TIME MILITARY 1630			
CRASH OCCURRED ON 1425 Columbus AVE.			WITHIN THE INTERSECTION OF Kroger Lot								
IF NOT IN INTERSECTION			(LIST NEAREST INTERSECTING STREET MILEPOST HOUSE NO)			CITY CODE					
LOG-1		LOG-2		LOC JUR FH3 FILT							
A	UNIT NO 1	NO OF OCCUPANTS	OPERATING <input type="checkbox"/>	PARKED <input type="checkbox"/>	DRIVERLESS <input type="checkbox"/>	HIT & RUN NON-CONTACT <input type="checkbox"/>	INSURANCE CO OR AGENT				
DRIVER-PEDESTRIAN NAME (LAST, FIRST, MI) UNKNOWN			ADDRESS (NO, STREET, CITY, STATE, ZIP CODE)								
PHONE NO		BIRTH DATE	AGE	SEX	SOCIAL SECURITY NO		STATE	DRIVER'S LICENSE NO	OCCUPATION		
OWNER (IF SAME AS DRIVER, WRITE SAME) UNKNOWN			ADDRESS					PHONE			
VEH YR	MAKE	MODEL	COLOR	STYLE	STATE	LICENSE PLATE NO	TOWING SERVICE	VEH PED DIR			
CIRCLE DAMAGE AREAS		9 TOP 10 UNDER CAR 11 LOAD 12 TRAILER		DAMAGE SEVERITY <input type="checkbox"/> NON-FUNCTIONAL <input type="checkbox"/> FUNCTIONAL <input type="checkbox"/> DISABLING		DAMAGE SCALE <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT <input type="checkbox"/> HEAVY		VEHICLE DISPOSITION <input type="checkbox"/> DRIVEN AWAY <input type="checkbox"/> REMAINED AT SCENE <input type="checkbox"/> TOWED			
FIRE <input type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE											
8	UNIT NO 2	NO OF OCCUPANTS 0	OPERATING <input type="checkbox"/>	PARKED <input checked="" type="checkbox"/>	DRIVERLESS <input type="checkbox"/>	HIT & RUN NON-CONTACT <input type="checkbox"/>	INSURANCE CO OR AGENT Geico				
DRIVER-PEDESTRIAN NAME (LAST, FIRST, MI)			ADDRESS (NO, STREET, CITY, STATE, ZIP CODE)								
PHONE NO		BIRTH DATE	AGE	SEX	SOCIAL SECURITY NO		STATE	DRIVER'S LICENSE NO	OCCUPATION		
OWNER (IF SAME AS DRIVER, WRITE SAME)			ADDRESS					PHONE			
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FIRE <input checked="" type="checkbox"/> NO FIRE <input type="checkbox"/> FIRE DUE TO CRASH <input type="checkbox"/> OTHER FIRE											
C	FROM UNIT NO	NAME (LAST, FIRST, MI)		BIRTH DATE	AGE	POSITION			INJURIES		
		ADDRESS		PHONE	SEX	A	B	C	D	E	F
D	FROM UNIT NO	NAME (LAST, FIRST, MI)		BIRTH DATE	AGE				1 FATAL 2 SERIOUS VISIBLE 3 MINOR VISIBLE 4 NO VISIBLE INJURY 5 NOT INJURED		
		ADDRESS		PHONE	SEX				CONDITION		
E	FROM UNIT NO	NAME (LAST, FIRST, MI)		BIRTH DATE	AGE				1 APPARENTLY NORMAL 2 SICK 3 FATIGUED 4 APPARENTLY ASLEEP 5 PHYSICAL DEFECT 6 OTHER CONDITION 7 UNKNOWN		
		ADDRESS		PHONE	SEX						
F	FROM UNIT NO	NAME (LAST, FIRST, MI)		BIRTH DATE	AGE						
		ADDRESS		PHONE	SEX						
A B C		INJURED TAKEN TO		By		A B C D E F			ALCOHOL		
D E F		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
A B C		INJURED TAKEN TO		By		A B C D E F			1 NO ALCOHOL DETECTED 2 HBD ABILITY IMPAIRED 3 HBD ABILITY NOT IMPAIRED 4 HBD ABILITY UNKNOWN		
D E F		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
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D E F		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
A B C		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
D E F		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
A B C		INJURED TAKEN TO		By		A B C D E F			A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED B <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> TESTED		
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